Response to RFC # 201101-01

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Current CSC HIE Capabilities

CSC is known to North Carolina Health Information Exchange (NC HIE) efforts based primarily on our contract with the NC Department of Health and Human Services (DHHS) in support of its public healthcare programs. In this capacity, CSC participates in the NC HIE Finance Workgroup. In our current role with DHHS, CSC will implement other new web-based capabilities, such as pharmacy electronic prescribing support and the reimbursement to practitioners in the Medicaid program throughout North Carolina.

In addition, CSC is currently involved in the following HIE activities in North Carolina:

- Coastal Connect Health Information Exchange – Assistance in determining HIE requirements.
- Carolinas HealthCare System – Established eligibility and reimbursement connectivity to payers.

At the same time, CSC is or has also been involved in HIE activities in other geographies that provide us with context for submitting comments:

- New England Healthcare Exchange Network (NEHEN) – CSC conceptualized and created this network in 1997. It currently serves over 200 healthcare organizations in Massachusetts and Rhode Island, processing over 100 million messages annually. Data types range from reimbursement-related ANSI X12 "HIPAA" transactions, to NCPDP SCRIPT e-prescribing, to HL7-based clinical summaries, lab results, quality measurement and public health reporting messages. CSC has served as program manager, technical partner since and custom solution developer continuously.
- Long Island Patient Information Exchange (LIPIX) – CSC serves as systems integrator and develops custom features on an InterSystems Corporation HealthShare platform.
- NY eHealth Collaborative (NYeC) – CSC has assisted in various phases of the New York Statewide Collaborative HIE activities since 2007, including Nationwide Health Information Network (NHIN) Trial implementations, and most recently in assisting with the identification of core and value-added services requirements, their alignment to state and federal policy drivers and an inventory of statewide RHIO capabilities. CSC currently participates in the NYeC Statewide Collaborative Technical Workgroup and Public Health Workgroup.
- New York State Department of Health – CSC provides online Medicaid reimbursement-related processing to 320 hospitals, 50,000 physicians and 30 health plans under contract to the state Department of Health. CSC has been continuously contracted with NYS DOH as Medicaid fiscal agent since 1982 and has provided online processing connectivity for over 10 years.
- Office of the National Coordinator for Health IT (ONC) – From 2005 to 2007, CSC was one of four original federal NHIN prototype contractors, connecting divergent RHIOs in Massachusetts, Indiana and California. Since 2009, CSC has been a participant in the NHINConnect collaborative workgroups for Protocols and Standards, Implementation, Privacy and Security. Since 2010, CSC has been a participant in the NHINdirect collaborative workgroups for Documentation and Testing and Privacy and Security.
- Other Statewide HIE efforts – CSC has assisted various aspects of statewide HIE activities and solutions in Arizona, Michigan and New Mexico.
- International efforts – CSC has planned and built significant HL7-based HIE capabilities in several western European nations, most notably for the National Health Service (NHS) in England and for the Netherlands Ministry of Health.

Comment Summary

CSC offers this commentary to help NC HIE determine how best to develop statewide HIE services to maximize stakeholder benefit. CSC's comments are based on our existing partnership with the DHHS and our in-depth experience with HIE implementation beyond North Carolina. We have been observers and participants in NC Operational Plan and NC HIE activities to date and believe that we can provide the most value at this time by commenting on core and value-added service and clinical function priorities; the process for refining HIE requirements; intersections with DHHS systems and infrastructure related to our NC Tracks contract; and guidance for the RFP / RFPs based on experience responding to similar RFPs in other settings.

Comments on Current Matrix of Statewide HIE Requirements

- The list of core services is generally complete and the separation between core and value-added services is reasonable.
- Many core service descriptions in their current form, however, need more detail and clarity. Current descriptions allow for too much interpretation by RFP respondents and will make it difficult for NC HIE to manage a vendor's scope of service unless further defined.
- Value-added service descriptions, in general, need even more requirement definition at this point than core services. For example, Patient Empowerment (Patient Engagement) needs more requirements development in areas such as support for a patient portal, populating PHRs, disseminating patient education services and patient/physician communication.
- Some service descriptions should account for current market realities, such as that HL7, HL7v2, and v3 transaction formats and adoption vary widely from vendor to vendor or provider to provider. In the section where NC HIE wants to create the "ability to provide transformation between different document formats" under Transformation Service, NC HIE should anticipate the complexity this circumstance will add to transformation requirements, and the impact this may have on desired timing and adoption. Based on this complexity, NC HIE should further consider if providing transformation services as a core HIE service enables NC HIE to deliver enough value soon enough to maintain stakeholder interest, or if a more federated approach to "last mile" integration will better meet stakeholders needs in the expected timeframes.
- Non-functional requirements (Privacy and Security, System Environments, Training, Help Desk and Hosting) are not consistently stated. Some are written as requirements and others as questions. These should be standardized going forward.
- Nearly all non-functional requirements are identified as "Step 1." NC HIE should consider deferring some non-functional requirements to later phases if possible.
- Step 1 standards are heavily weighted to an IHE implementation. This is reasonable based on IHE's maturity relative to other standards that are not yet well-defined or adopted, such as NHINdirect. However, NC HIE should recognize that implementing an IHE-based solution in the short term may require considerable rework and enhancement for subsequent steps as other interoperability standards gain acceptance.

Comments on Current and Helpful Clinical Functions

Clinical functions need more specific definition and clarity. They allow for prioritizing between "Facilitate effective coordination of care" and "Provide tools to enhance delivery of care," for example, but not for prioritizing among specific clinical priorities. CSC recommends defining a set of high level use cases to facilitate workgroup discussions, prioritization of functions and services into steps and RFP creation. Examples of potential use cases include:

- Route primary care physician data to other authorized parties to support referrals
- Route hospital data to providers and other authorized parties to transfers of care
- Route lab and imaging orders and results
- Query patient history

- Route electronic prescriptions
- Retrieve medication history for medication reconciliation and other medication management
- Route visit and other data for clinical decision support
- Route data to patients
- Adjudicate and manage claims and/or patient responsibility
- Route visit and other data for standardized quality reporting and/or public health reporting

CSC would welcome an opportunity to discuss with NC HIE how we have used this approach to facilitate prioritization in other states.

RFP Guidance and Recommendations

- Produce and include in the RFP a "Concept of Operations" for the long-term operation, funding and support for core and value added HIE services so that bidders can include and comment on features and sustainability plans beyond the HIE development stage. Articulate how the HIE capability sought in an RFP aligns with state and federal policy, now and over time, and a vision for sustainability.
- Clearly spell out how "qualified organizations" will be qualified / accredited and clearly identify the services boundary between them and statewide HIE services / service providers.
- Clearly define the role any existing RHIOs and state agencies and systems are expected to play, including whether RHIOs can respond to any RFPs in a bid to provide statewide services.
- Spell out if / how NC HIE services will be expected to interact with NHINConnect and NHINDirect project capabilities, including the expected role of Health Information Service Providers (HISPs) and requirements for SOAP / SMTP multi-protocol support, if any.
- Develop an adoption model for how RHIOs / HIOs, hospitals, qualified organizations, HISPs, etc.) will be expected to be supported over what period. This will provide a common set of assumptions for bidders encourage realistic and quantifiable "apples-to-apples" scalability models. Recognize that not all provider organizations will adopt HIE immediately. Ask RFP respondents to outline how scalable their solutions are and how they will support or promote adoption over time. Set expectations with RFP respondents of how "last mile" integration is handled.
- Set expectations for if / how non-providers participate, including state Medicaid, commercial payers, patients, researchers, quality measurement organizations, public health agencies, and other stakeholders.
- Spell out how existing state agency infrastructure and capabilities are expected to be used in HIE, especially any leverage of Medicaid, Health Choice, Public Health, and Rural Health infrastructure.
- Avoid the trap some other states have encountered by recognizing that no HIE vendors have a "magic bullet" approach to enabling HIE for everyone, or that EMR vendors have built standard interfaces for HIE integration. Our experience is that vendor claims of standard interfaces are overstated. Since most non-qualified organizations (small provider offices, etc.) are dependent on electronic medical record (EMR) vendors to develop solutions, it will be impossible for HIE service providers to support all variations in the marketplace. Exclude or limit support for large numbers of non-qualified organizations from the RFP.
- Instead of issuing one RFP for all HIE services expected over time, use a phased implementation approach for a series of achievable successes at no more than 9 month intervals that will enable stakeholders to realize early benefit and payback and to claim victory to the community. Consider separate and sequenced RFPs / procurements for specialized core services (e.g., separate RFPs for provider directory and RLS / Patient Matching) and areas of expertise (e.g., for privacy and security policy). Further, make sure RFPs are for service "bundles" that are codependent or required in order to deliver full business value (i.e., it may make sense to bundle Consent Management with RLS / Patient Matching, Identity Management and Authentication with Provider Directory, Transaction Logging and Transformation with Message / Record Routing, etc., at least for Step 1 features).